Intake Form

Process Therapy Institute

This form seeks to obtain basic information to begin our work together. I believe in the right to privacy and self determination for each of my clients. Please provide the following information as best as you can, but you have the right to decline sharing any of this information. Please note that the information you provide here is protected as confidential information. Complete this form and bring it to your first session.

Name_____ Preferred Name_____

Pronouns_____ Birth Date_____ Age_____

Below circle all that apply to you.

Primary Ethnicity

European American/White Native American African American Asian American

Latinx American Multiethnic_____ Something Else_____

Gender

Female Male Transgender Female Transgender Male GenderQueer

Something Else_____ Don't Know Choose Not to Disclose

Sexual Orientation

Heterosexual Lesbian Gay Bisexual Questioning

Pansexual Asexual Something Else_____ Choose Not to Disclose

Relational Status

Single Widowed Divorced Partnered Married Dating

If in a relationship, please include nature and length of relationship.

_____

Are you currently employed? If yes, please describe your work and how long you've been working.

_____

Do you have religious or spiritual beliefs? If yes, describe your faith or belief.

_____

What is your level of education?_____

Please list any children and their age(s):

_____

Do you live with anyone? If yes, who do you live with and describe your current living situation.

_____

Do you feel safe at home?

_____

Contact Information

Address_____

Phone_____ May we leave a message? Yes No

Email_____ May we email you? Yes No

Referred by_____

Your Emergency Contact

Name_____ Number_____

Your relationship to this person_____

History of Mental Health

Have you previously received any type of mental health services? If yes, when, for how long, what brought you in, and were you satisfied with their services?

_____

_____

Have you ever been prescribed psychiatric medication? Please list and provide dates.

_____

Have you ever been hospitalized for a psychiatric issue? Yes No

General Health and Mental Health Information

Who is your current primary care physician? Please include their phone number.

_____

When was your last

physical?_____

Are you currently taking any prescription medication, including hormones or birth control? Please list them and the reason for taking them.

_____

_____

Rate your current physical health 0-10 (0 is unhealthy and 10 is healthy):_____

Rate your current sleeping habits 0-10 (0 is unhealthy and 10 is healthy):_____

How many times per week do you generally exercise?_____

Please list any specific health problems you are currently experiencing:

_____

Please list any specific sleep problems your are currently experiencing:

_____

Please list the types of exercise you participate in:_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

Are you currently experiencing overwhelming sadness, grief, or depression? If yes, for approximately how long?

_____

Are you currently experiencing anxiety, panic attacks or any phobias? If yes, when did you begin experiencing this and for how long?

_____

Are you currently experiencing any chronic pain? If yes, please describe.

_____

Are you currently experiencing any suicidal thoughts? Yes No
Have you ever attempted suicide? Yes No
Do you have thoughts or urges to harm others? Yes No
Do you drink alcohol? If yes, how often?_____
Do you use caffeine? If yes, how often?_____
Do you use cannabis? If yes, how often?_____
Do you engage in recreational drug use? If yes, how often?_____
Are you sexually active? If yes, how often? _____
Do you have any concerns regarding sexuality that you would like to explore?

_____

What significant life transitions or stressful events have you experienced recently?

_____

Please circle all that apply to you. Indicate if these are historical or current conditions.

Headaches/Migraines
High blood pressure
Gastritis or esophagitis
Hormone-related problems
Head injury
Angina or chest pain
Irritable bowel
Loss of Consciousness
Heart Attack
Bone or joint problems
Seizures
Kidney-related issues
Chronic fatigue
Dizziness
Faintness
Heart valve problems
Urinary tract problems
Fibromyalgia
Numbness & tingling
Shortness of breath
Diabetes
Hepatitis
Asthma
Arthritis
Thyroid issues
HIV/AIDS
Cancer
Other _____
Low motivation
Isolation from others
Low self-esteem
Depressed mood
Tearful or crying spells
Hopelessness
Low energy
Decreased appetite
Increased appetite
Trouble Concentrating
Problems with sleep
Fear or Anxiety

Family Mental Health History

In the section below identify if there is history of any of the following within your blood relatives or other relatives, including adoptive or otherwise. If yes, please indicate the relative's relationship to you in the space provided.

Alcohol/Substance Abuse	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Domestic Violence	Yes	No	_____
Eating Disorders	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
Suicide Attempts	Yes	No	_____

Additional Information

What brings you to therapy at this time? Is there something specific, such as a particular event?

_____

_____

What are your goals for therapy?

_____

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

What else would you like me to know?

_____

_____